Claims Clues

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Many Family Planning Claims Need FP Modifier

Fee-for-service claims for AHCCCS recipients eligible for family planning services only must properly identify the service being billed as a family planning service.

The AHCCCS Administration has defined the procedure codes that require an FP modifier and those services that do not require an FP modifier when billed on the HCFA 1500 claim form.

The procedures listed below are the *only* codes that may be billed to AHCCCS for family planning and sterilization services provided to recipients eligible for family planning services only.

The FP Modifier is **NOT** required for the following services:

11975 Norplant insertion and drug
11976 Norplant removal
55250 Vasectomy, unilateral or bilateral
55450 Ligation of vas deferens
58670 Laparoscopy, surgical
58671 Laparoscopy, surgical
57170 Diaphragm fitting with instructions
58300 Insertion of intrauterine device
58301 Removal of Intrauterine device
58600 Ligation of tubes, abdominal or vaginal
58605 Post-partum tubal ligation
58611 Tubal ligation with cesarean section
58615 Occlusion of fallopian tubes by device
A4261 Cervical cap
J1055 Depo-provera (150mg)

The FP Modifier **IS** required for the following services:

99201 - Office or other outpatient visit
99202 - Office or other outpatient visit
99203 - Office or other outpatient visit
99204 - Office or other outpatient visit
99255 - Office or other outpatient visit
99211 - Office or other outpatient visit
99212 - Office or other outpatient visit
99213 - Office or other outpatient visit
99214 - Office or other outpatient visit
99215 - Office or other outpatient visit
99217 - Observation care discharge day management
99221 - Initial hospital care, per day
99231 - Subsequent hospital care, per day
99232 - Subsequent hospital care, per day
99233 - Subsequent hospital care, per day
99241 - Office consultation
99242 - Office consultation
99243 - Office consultation
99000 - Handling and/or conveyance of specimen
G0001 - Venipuncture
81000 - Urinalysis by dipstick or tablet reagent
81025 - Urine pregnancy test
82948 - Glucose; blood, reagent strip
82951 - Glucose; tolerance test (GTT)
84702 - Gonadotropin, chorionic (hCG)
84703 - Gonadotropin, chorionic (hCG)
88302 - Surgical pathology
85014 - Blood count; other than hemocrit
85018 - Blood count; hemoglobin
85021 - Blood count; hemogram, automated
86592 - Syphilis test; qualitative
86593 - Syphilis test; quantitative
86689 - HTLV or HIV confirmatory
86701 - Antibody; HIV-1
86702 – Antibody; HIV-2
86703 - Antibody, HIV-1 and HIV-2
86706 - Hepatitis B (HBsAb)
86781 - Antibody; Treponema Pallidum
87075 - Culture, bacterial, any source
87106 - Culture, fungi
87110 - Culture, chlamydia
87207 - Smear, primary source
87210 - Smear, primary source
87211 - Smear, primary source
87250 - Virus identification
87350 - Hepatitis Be antigen (HBeAg)
87390 - HIV-1
87391 - HIV-2
88150 - Cytopathology, slides
88152 - Cytopathology, slides
88153 - Cytopathology, slides
88154 - Cytopathology, slides
88155 - Cytopathology, slides ❒

Guidelines Offered for QMB Only Claims

Providers who submit QMB Only claims to the AHCCCS Administration can help expedite processing of these claims by ensuring that claim forms are completed properly.

When submitting QMB Only claims, providers must follow these claim submission rules:

Coinsurance and Deductible

The Medicare coinsurance and deductible, if applicable, must be entered in Field 24K of the HCFA 1500 claim form. Enter the coinsurance first and the deductible as the second figure. Providers may not "zero fill" both of these fields. If Medicare denies a claim, AHCCCS will not reimburse the provider.

When submitting a HCFA 1500 claim for a Medicare HMO member, the charges in Field 24F must be the provider's billed charges, not the co-pay amount. The co-pay amount must be entered in Field 24K as coinsurance with a zero entered as the deductible.

Coinsurance and deductible must be entered in Field 41 of the UB-92 claim form using value code A1 to indicate Part A deductible and A2 for Part A coinsurance, if applicable.

Provider ID Number

Providers must enter their AHCCCS provider ID and 2-digit locator code in the "PIN#" section of Field 33 of the HCFA 1500. A facility's AHCCCS provider ID number must be entered in Field 51 of the UB-92.

Submission of Claims

Providers should send QMB only fee-for-service claims to:

AHCCCS Administration
Attn: Lori Petre
P.O. Box 25520
Phoenix, AZ 85002

Providers should write "QMB Only" on the envelope and include the Medicare EOMB with the claim.

Providers with questions about QMB Only claims should call the Claims Customer Service Unit at (602) 417-7670 (Option 4).

The following policies apply solely to QMB Only claims:

- Timeliness requirements
  - QMB Only claims will be considered timely if initially received by AHCCCS within six months from the date of Medicare payment.
  - The claim must achieve clean claim status within 12 months from the date of Medicare payment.
- UB-92 discounts/penalties
  - AHCCCS will not take a quick pay discount nor pay a slow pay penalty on UB-92 QMB Only claims. ❒

A0888 Limited to Emergency Air Transportation

Only emergency air transportation providers may report non-covered mileage to the AHCCCS Administration using HCPCS code A0888 (Non-covered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)).

NOTE: This code may only be used when billing for services for Medicare members.

Ground ambulance providers are restricted from billing this code effective with claims for dates of service on and after March 15, 2000.

Ground ambulance providers may use the AHCCCS-specific code Z3655 to report non-covered mileage. ❒

Coding Corner

The AHCCCS Administration has made the following changes to its Reference subsystem:

- Add Z3715 (Helicopter taxi – non-emergency) for **air transportation** providers effective 08/10/1999

Provider type 02 (Hospital)

- Add Z3610 effective 10/01/1999

Provider type 11 (Psychologist)

- Add 90899 effective 10/01/1999

Provider type 23 (Home health)

- Add category of service 46 (Environmental) effective 10/01/1996

Provider type 24 (Personal care)

- Add category of service 46 (Environmental) effective 10/01/1996

Provider type 37 (Homemaker)

- Add category of service 46 (Environmental) effective 10/01/1996

Provider type 39 (Habilitation provider)

- Add category of service 46 (Environmental) effective 10/01/199